Child Fatality Report Release of Information to the Public

Person ID: 112736415

County of Child's Residence: MIDLAND

Gender: Female

Age: 0 Year(s) 8 Month(s)

Date of Death: 03/04/2024

On the date of the fatality, the child was not in DFPS conservatorship and was living with the child's parent, a managing conservator, a legal guardian or other person entititled to the child's possession.

Child's Name: Neal,Harmani

Current Report(s) of Abuse/Neglect:

Intake Date(s): 2/19/2024, 3/05/2024 - two reports merged into single investigation

Summary of Allegation(s)/Investigation:

The Department received a report medical staff were concerned due to the deceased child's mother needing assistance with formula after she reported being robbed. Due to this robbery, the deceased child lost medical equipment and other needed supplies. There were also concerns the deceased child's mother missed medical visits for the deceased child. There are primary concerns of failure to thrive, poor weight gain and extremely delayed milestones. The Department received a second report several weeks later stating law enforcement responded to the home where the child was already determined to be deceased. The home was not in good condition, with electricity in only half of the residence. There was no water in the home, with the deceased child's mother with gallons of distilled water for bottles. There were also alcohol and liquor bottles observed all over the residence.

The Department determined upon initial contact the deceased child was observed clean and dressed appropriately. The deceased child's mother and an unrelated home member were both seen bonding and caring and meeting the deceased child's needs. The deceased child's mother advised she rescheduled the appointment due to the pediatrician office telling them that they could schedule transportation with Medicaid 2 days prior and they were advised by Medicaid that it needed to be a minimum of 5 days. The appointment was rescheduled for 3/5/2024.

After the report was received of the fatality, it was determined there were multiple inconsistencies regarding what

happened to the deceased child. The deceased child did miss numerous medical appointments and the mother had rescheduled several, reporting she was having issues with transportation. The mother admitted to smoking marijuana in and around the residence where the deceased child was. The home had notable indications that a party had taken place the night before the fatality. There were bottles of alcohol and cigarettes throughout the home. The deceased child had a blood alcohol content of .172 post-mortem. The alcohol is was provided to the child through direct administration, as the child's development was not such that this could have occurred otherwise. The deceased child's mother showed little to no emotion, did not cry, or appear upset about the death.

The Department consulted child abuse medical professionals with the Forensic Assessment Center Network, who noted extremely poor weight gain throughout her life and nutritional neglect from malnutrition, and non-compliance from developmental services. Due to the significant delays in gross and fine motor skills, the deceased child would have been unable to independently ingest alcohol without assistance. Symptoms of alcohol toxicity could include seizures, lethargy, hypoglycemia and death. Presence of alcohol in the deceased child's blood indicates direct administration and this is indicative of physical neglect and assault by poisoning.

The medical examiner conducted an autopsy and the cause of death was acute alcohol poisoning. The manner of death was ruled homicide.

Law enforcement conducted an investigation and was pursuing charges of murder however no arrests or charges had been made at the time of the Department's investigation closing.

Investigation Findings:

The Department confirmed the deceased child's mother committed physical abuse of the deceased child, which led to her death.

The Department confirmed the deceased child's mother committed neglectful supervision of the deceased child.

The Department was unable to determine if the deceased child's mother committed medical neglect of the deceased child.

The Department did not confirm the deceased child's mother committed physical neglect of the deceased child.

Safety and Risk Assessment Factors Identified:
2/23/2024: Safety Assessment - Initial: Safe
Risk Assessment Final Risk Level: Very High

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Other Services:

No services or referrals were provided.

No Service Referrals and deceased child was an only child.

Other Actions Taken to Mitigate Risk:

None

If one or more children were previously removed from the home, for each conservatorship episode, summarize dates of conservatorship and type of placement at the end of conservatorship:

Not applicable

Previous Report of Abuse/Neglect:

Intake Date(s): 5/05/2021, 9/23/2021 - two reports merged into single investigation

Summary of Previous Allegation(s)/Investigation:

The Department received a report upon the birth of the deceased child's older sibling due to the mother admitting to marijuana usage during pregnancy. The sibling was born prematurely at 34 weeks and is suspected to have abnormalities and complications with the brain. There were concerns for mother's ability to parent and had missed an appointment with a specialist previously. An additional report was received when the sibling was four months of age. The sibling was still in the hospital and staff had concerns due to the mother's inability or unwillingness to learn to care for the sibling, who would require a high level of care upon discharge. The mother and sibling had tested positive for marijuana at birth, and the mother and grandmother continue to smell of marijuana.

The Department determined that the sibling's urine did not test positive for any substances. Mother admitted to smoking marijuana prior to the birth of the sibling, and has continued to do so. She tested positive for marijuana on a urine test. The sibling had significant medical needs, required a feeding tube and a trach, and remained in the Neonatal Intensive Care Unit. These medical issues were unrelated to the mother's drug use and due to a neuro degenerate disorder. The sibling passed away on 11/5/2021 at the hospital.

Investigation Findings:

The Department did not confirm the mother committed medical neglect or neglectful supervision of the sibling.

Safety and Risk Assessment Factors Identified:
5/7/2021: Safety Assessment - Initial: Safe
Risk Assessment Final Risk Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Counseling and Evaluation

Other Services:

The mother declined referrals to counseling services.

No Service Referrals and deceased child was an only child.

Other Actions Taken to Mitigate Risk:

None

Previous Report of Abuse/Neglect:

Intake Date(s): 5/03/2022

Summary of Previous Allegation(s)/Investigation:

The Department received a report due to concerns that an eleven-month-old child with special needs was residing in a home that was not safe. The home was said to have rats, trash everywhere, and only one toilet that works that is full of feces. It was also reported the grandmother used drugs.

The Department determined that the eleven-month-old child in the report was the deceased child's sibling, who had passed away in the prior investigation. The mother has no other children at the time of this report so the investigation was administratively closed.

Investigation Findings:

The concerns of physical neglect against the deceased sibling were administratively closed.

Safety and Risk Assessment Factors Identified:

Case Action:

ADMIN - Refute the Allegations

Services and Referrals Provided to the Family:

Other Services:

Not applicable

No Service Referrals and deceased child was an only child.

Other Actions Taken to Mitigate Risk:

Not applicable

Previous Report of Abuse/Neglect:

Intake Date(s): 12/20/2023

Summary of Previous Allegation(s)/Investigation:

The Department received a report stating the deceased child has failure to thrive, abnormal neonatal screenings for cystic fibrosis, pulmonary artery stenosis, infantile spasms, and delayed milestones. The mother is not following up with critical medical appointments and is inconsistent with medical care that could seriously impact the child's overall health and wellness. The mother was also said to have poor social support.

The Department determined that the child had missed numerous appointments, but had also attended appointments at the pediatrician for monitoring of weight gain. She would reschedule and attend some appointments but no show other appointments and then reschedule those. Many appointments were missed, per the mother, due to transportation issues. The child's cardiologist was contacted who reported no missed appointments in their office. During the investigation, the mother moved and her new residence was without

running water and in poor condition but not a safety hazard to the child. The mother reported they would bathe at the maternal great grandmothers home, which the grandmother confirmed, along with assisting in taking the mother and child to some appointments. Referral information to services and supports for Parenting Special Medical Needs Children and Mommy and Me were made, as recommended by the Department's well-being specialist.

Investigation Findings:

The Department did not confirm that mother committed medical neglect of the child.

Safety and Risk Assessment Factors Identified:
12/21/2023: Safety Assessment - Initial: Safe
2/2/2024: Safety Assessment - Reassessment: Safe
Risk Assessment Final Risk Level: Moderate

Safety and Risk Assessment Factors Identified:

Case Action:

Close

Services and Referrals Provided to the Family:

Counseling and Evaluation,Parent/Caregiver Training,Basic Needs Support

Other Services:

The mother accepted basic needs support and referrals to counseling and evaluation services, parent training, and support groups.

Other Actions Taken to Mitigate Risk:

None

Other Previous Report of Abuse/Neglect:

Intake Date(s):

Summary of Previous Allegation(s)/Investigation:

Investigation Findings:

Safety and Risk Assessment Factors Identified:

Case Action:

Services and Referrals Provided to the Family:

Other Services:

Other Actions Taken to Mitigate Risk:

Note: This report was prepared on 05/12/2026 and does not include corrections or updates, if any, that may be subsequently made to DFPS data on or after the date this report was prepared.